

Complete Summary

GUIDELINE TITLE

Clinical guideline on behavior guidance for the pediatric dental patient.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry (AAPD). Clinical guideline on behavior guidance for the pediatric dental patient. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2005. 12 p. [57 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Academy of Pediatric Dentistry. Clinical guideline on behavior management. Chicago (IL): American Academy of Pediatric Dentistry; 2000. 6 p.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Pediatric dental diseases

GUIDELINE CATEGORY

Counseling
 Management
 Prevention

Risk Assessment
Treatment

CLINICAL SPECIALTY

Dentistry
Pediatrics

INTENDED USERS

Allied Health Personnel
Dentists
Health Care Providers
Nurses
Patients
Physicians

GUIDELINE OBJECTIVE(S)

To provide definitions, objectives, indications, and contraindications for behavior guidance techniques useful in pediatric dentistry

TARGET POPULATION

Infants, children, and adolescents undergoing dental procedures

INTERVENTIONS AND PRACTICES CONSIDERED

Behavior Guidance Techniques

1. Obtaining informed consent
2. Patient communication
3. Dentist behavior
4. Patient assessment
5. Presence/absence of parents
6. Tell-show-do technique
7. Voice control
8. Nonverbal communication
9. Positive reinforcement
10. Distraction
11. Nitrous oxide/oxygen inhalation
12. Hand over mouth technique
13. Protective stabilization
14. Sedation
15. General anesthesia

MAJOR OUTCOMES CONSIDERED

- Co-operative patient behavior
- Patient satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

MEDLINE searches were done using the terms "behavior management in children," "child behavior and dentistry," "child personality and test," "child preschool personality and test," "patient cooperation," "dentists and personality," "dentist-patient relations," "patient assessment," "child and dental anxiety," "child preschool and dental anxiety," "restraint," "Joint Commission on Accreditation of Healthcare Organizations," "American Academy of Pediatrics," "treatment deferral," "treatment planning," "hand over mouth," "behavior management in dentistry," and "aversive techniques." Every effort was made to base this guideline on evidence-based literature; however, some recommendations are based on best clinical practice and expert opinion.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The oral health policies and clinical guidelines of the American Academy of Pediatric Dentistry (AAPD) are developed under the direction of the Board of

Trustees, utilizing the resources and expertise of its membership operating through the Council on Clinical Affairs (CCA).

Proposals to develop or modify policies and guidelines may originate from 4 sources:

1. The officers or trustees acting at any meeting of the Board of Trustees
2. A council, committee, or task force in its report to the Board of Trustees
3. Any member of the AAPD acting through the Reference Committee hearing of the General Assembly at the Annual Session
4. Officers, trustees, council and committee chairs, or other participants at the AAPD's Annual Strategic Planning Session

Regardless of the source, proposals are considered carefully, and those deemed sufficiently meritorious by a majority vote of the Board of Trustees are referred to the CCA for development or review/revision.

Once a charge (directive from the Board of Trustees) for development or review/revision of an oral health policy or clinical guideline is sent to the CCA, it is assigned to 1 or more members of the CCA for completion. CCA members are instructed to follow the specified format for a policy or guideline. All oral health policies and clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field. Members may call upon any expert as a consultant to the council to provide expert opinion. The Council on Scientific Affairs provides input as to the scientific validity of a policy or guideline.

The CCA meets on an interim basis (midwinter) to discuss proposed oral health policies and clinical guidelines. Each new or reviewed/revised policy and guideline is reviewed, discussed, and confirmed by the entire council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Once developed by the Council on Clinical Affairs (CCA), the proposed policy or guideline is submitted for the consideration of the Board of Trustees. While the board may request revision, in which case it is returned to the council for modification, once accepted by majority vote of the board, it is referred for Reference Committee hearing at the upcoming Annual Session. At the Reference Committee hearing, the membership may provide comment or suggestion for

alteration of the document before presentation to the General Assembly. The final document then is presented for ratification by a majority vote of the membership present and voting at the General Assembly. If accepted by the General Assembly, either as proposed or as amended by that body, the document then becomes the official American Academy of Pediatric Dentistry (AAPD) oral health policy or clinical guideline for publication in the AAPD's Reference Manual and on the AAPD's Web site.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Background Summary

1. Behavior guidance is based on scientific principles. The proper implementation of behavior guidance requires an understanding of these principles. Behavior guidance, however, is more than pure science and requires skills in communication, empathy, coaching, and listening. As such, behavior guidance is a clinical art form and skill built on a foundation of science.
2. The goals of behavior guidance are to establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between dentist and child, and promote the child's positive attitude towards oral/dental health and oral health care.
3. The urgency of the child's dental needs must be considered when planning treatment. Deferral or modification of treatment sometimes may be appropriate until routine care can be provided using communicative guidance techniques.
4. All decisions regarding behavior guidance must be based on a benefit vs risk evaluation. Parents share in the decision-making process regarding treatment of their children.
5. The dental staff must be trained carefully to support the doctor's efforts and properly welcome the patient and parent into a child-friendly environment that will facilitate behavior guidance and a positive dental visit.

Basic Behavior Guidance

Communication and Communicative Guidance

Communication is the imparting or interchange of thoughts, opinions, or information. This interchange may be accomplished by a number of means but, in the dental setting, it is affected primarily through speech, tone of voice, facial expression, and body language. The four "essential ingredients" of successful communication are: 1) the sender; 2) the message, including the facial expression and body language of the sender; 3) the context or setting in which the message is sent, and 4) the receiver. In order for successful communication to take place, all 4 elements must be present and consistent. Without that consistency, there may be a poor "fit" between the intended message and what is understood.

Communicating with children poses special challenges for the dentist and the dental team. A child's cognitive development will dictate the level and amount of

information interchange that can take place with an adult. It is impossible for a child to perceive an idea for which he has no conceptual framework. It is important for the dentist to have a basic concept of the cognitive development of children so that, through appropriate vocabulary, messages can be sent that are consistent with the receiver's intellectual development. It is unrealistic to expect a child dental patient to adopt the dentist's frame of reference.

The importance of the context in which messages are delivered cannot be overstated. The dental office may be made "child friendly" by the use of themes in its decoration, age appropriate toys and games in the reception room or treatment areas, and smaller scale furniture. However, the operatory may contain distractions for children that may be anxiety-producing (e.g., hearing another child cry), and may interfere with communication. Dentists and other members of the dental team may find it advantageous to provide certain information (e.g., post-operative instructions, preventive counseling) in an area away from the dental operatory where many items may distract the child. Communication also is impaired when the sender's expression and body language are not consistent with the intended message. The dentist whose body language conveys uncertainty, anxiety, or urgency cannot effectively communicate confidence in his/her clinical skills. The 3 "essential communications" imparted to child patients through primarily nonverbal means are:

- "I see you as an individual and will respond to your needs as such."
- "I am thoroughly knowledgeable and highly skilled."
- "I am able to help you and will do nothing to hurt you needlessly."

It is possible to communicate with the child patient briefly at the start of a dental appointment to establish rapport and trust. However, once the dental procedure has begun, the dentist's ability to control and shape behavior becomes paramount, and information sharing becomes secondary. The two-way interchange of information gives way to one-way manipulation of behavior through commands. This type of interaction is called "requests and promises." When action must take place to reach a goal (e.g., completion of the dental procedure), the dentist assumes the role of the requestor. Requests elicit promises from the patient which, in turn, establish a commitment to cooperate. The dentist may have to frame the request in a number of ways in order to make the request effective. Reframing a previously-given request in an assertive voice, for example, with appropriate facial expression and body language, is the basis for the technique of voice control. While voice control is classified as one of the means of communicative guidance, it may be considered aversive in nature by some parents.

Communicative management and appropriate use of commands are used universally in pediatric dentistry with both the cooperative and uncooperative child. In addition to establishing a relationship with the child and allowing for the successful completion of dental procedures, these techniques may help the child develop a positive attitude toward oral health. Communicative management comprises a host of techniques that, when integrated together, enhance the evolution of a cooperative patient. Rather than being a collection of singular techniques, communicative management is an ongoing subjective process that becomes an extension of the personality of the dentist. Associated with this process are the specific techniques of voice control, nonverbal communication,

tell-show-do, positive reinforcement, distraction, and parental presence/absence. The dentist should consider the cognitive development of the patient, as well as the presence of other communication deficits (e.g., hearing disorder), when choosing specific communicative management techniques. For the majority of patients, these techniques are considered elements of usual and customary communication, and as such, no specific consent or documentation is necessary prior to use.

Dentist Behavior

Few healthcare providers have conscious insight into how they communicate. The health professional may be inattentive to communication style, but patients/parents are very attentive to it. The communicative behavior of dentists is a major factor in patient satisfaction. The dentist should recognize that not all parents may express their desire for involvement. Dentist behaviors reported to correlate with low parent satisfaction include rushing through appointments, not taking time to explain procedures, barring parents from the examination room, and generally being impatient. Relationship/communication problems have been demonstrated to play a prominent role in initiating malpractice actions. Even where no error occurred, perceived lack of caring and/or collaboration was associated with litigation.

Studies of efficacy of various dentist behaviors in management of uncooperative patients are equivocal. Dentist behaviors of vocalization, direction, empathy, persuasion, giving the patient a feeling of control, and operant conditioning have been reported as efficacious responses to uncooperative patient behaviors.

Patient Assessment

The response of a child patient to the demands of dental treatment is complex and determined by many factors. Multiple studies have demonstrated that a minority of children with uncooperative behavior have dental fears and that not all fearful children are dental behavior management problems. Child age/cognitive level, temperament/personality characteristics, anxiety and fear, reaction to strangers, previous dental experiences, and maternal dental anxiety influence a child's reaction to the dental setting.

The dentist should include an evaluation of the child's cooperative potential as part of treatment planning. Information can be gathered by observation of and interacting with the child and by questioning the child's parent. Ideal assessment methods are valid, allow for limited cognitive and language skills, and are easy to use in a clinical setting. Assessment tools that have demonstrated some efficacy in the pediatric dental setting, along with a brief description of their purpose, are listed in Appendix 1 of the original guideline document. No single assessment method or tool is completely accurate in predicting a child patient's behavior for dental treatment, but dentist awareness of the multiple influences on child behavior may aid in treatment planning for the pediatric patient.

Parental Presence/Absence

Description: The presence or absence of the parent sometimes can be used to gain cooperation for treatment. A wide diversity exists in practitioner philosophy

and parental attitude regarding parents' presence or absence during pediatric dental treatment. Parenting styles in America have been evolving in recent decades. Practitioners are faced with challenges from an increasing number of children who many times are ill-equipped with the coping skills and self-discipline necessary to deal with new experiences in the dental office. Frequently, parental expectations for the child's behavior are unrealistic, while those for the dentist to guide their behavior are great. Practitioners agree that good communication is important among the dentist, patient, and parent. Practitioners also are united in the fact that effective communication between the dentist and the child is paramount and requires focus on the part of both parties. Children's responses to their parents' presence or absence can range from very beneficial to very detrimental. It is the responsibility of each practitioner to determine the communication and support methods that best optimize the treatment setting recognizing his/her own skills, the abilities of the particular child, and the desires of the specific parent involved.

Objectives:

1. Gain the patient's attention and improve compliance
2. Avert negative or avoidance behaviors
3. Establish appropriate dentist-child roles
4. Enhance effective communication among the dentist, child, and parent
5. Minimize anxiety and achieve a positive dental experience

Indications: May be used with any patient

Contraindications: Parents who are unwilling or unable to extend effective support (when asked)

Tell-Show-Do

Description: Tell-show-do is a technique of behavior shaping used by many pediatric professionals. The technique involves verbal explanations of procedures in phrases appropriate to the developmental level of the patient (tell); demonstrations for the patient of the visual, auditory, olfactory, and tactile aspects of the procedure in a carefully defined, non-threatening setting (show); and then, without deviating from the explanation and demonstration, completion of the procedure (do). The tell-show-do technique is used with communication skills (verbal and nonverbal) and positive reinforcement.

Objectives:

1. Teach the patient important aspects of the dental visit and familiarize the patient with the dental setting
2. Shape the patient's response to procedures through desensitization and well-described expectations

Indications: May be used with any patient

Contraindications: None

Voice Control

Description: Voice control is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior. Parents unfamiliar with this technique may benefit from an explanation to prevent misunderstanding.

Objectives:

1. Gain the patient's attention and compliance
2. Avert negative or avoidance behavior
3. Establish appropriate adult-child roles

Indications: May be used with any patient

Contraindications: Patients who are hearing impaired

Nonverbal Communication

Description: Nonverbal communication is the reinforcement and guidance of behavior through appropriate contact, posture, and facial expression.

Objectives:

1. Enhance the effectiveness of other communicative management techniques
2. Gain or maintain the patient's attention and compliance

Indications: May be used with any patient

Contraindications: None

Positive Reinforcement

Description: In the process of establishing desirable patient behavior, it is essential to give appropriate feedback. Positive reinforcement is an effective technique to reward desired behaviors and thus strengthen the recurrence of those behaviors. Social reinforcers include positive voice modulation, facial expression, verbal praise, and appropriate physical demonstrations of affection by all members of the dental team. Nonsocial reinforcers include tokens and toys.

Objective: Reinforce desired behavior.

Indications: May be useful for any patient

Contraindications: None

Distraction

Description: Distraction is the technique of diverting the patient's attention from what may be perceived as an unpleasant procedure. Giving the patient a short

break during a stressful procedure can be an effective use of distraction prior to considering more advanced behavior guidance techniques.

Objectives:

1. Decrease the perception of unpleasantness
2. Avert negative or avoidance behavior

Indications: May be used with any patient

Contraindications: None

Nitrous Oxide/Oxygen Inhalation

Description: Nitrous oxide/oxygen inhalation is a safe and effective technique to reduce anxiety and enhance effective communication. Its onset of action is rapid, the effects easily are titrated and reversible, and recovery is rapid and complete. Additionally, nitrous oxide/oxygen inhalation mediates a variable degree of analgesia, amnesia, and gag reflex reduction.

The need to diagnose and treat, as well as the safety of the patient and practitioner, should be considered before the use of nitrous oxide/oxygen analgesia/anxiolysis. Detailed information concerning the indications, contraindications, and additional clinical considerations may be found in the American Academy of Pediatric Dentistry's (AAPD) Clinical Guideline on Appropriate Use of Nitrous Oxide for Pediatric Dental Patients.

Advanced Behavior Guidance

Most children can be managed effectively using the techniques outlined in basic behavior guidance. These basic behavior guidance techniques should form the foundation for all of the management activities provided by the dentist. However, children occasionally present with behavioral considerations that require more advanced techniques. The advanced behavior guidance techniques include hand-over-mouth (HOM), protective stabilization, sedation, and general anesthesia. They are extensions of the overall behavior guidance continuum with the intent to facilitate the goals of communication, cooperation, and delivery of quality oral health care in the difficult patient. Appropriate diagnosis of behavior and safe and effective implementation of these techniques necessitate knowledge and experience that is generally beyond the core knowledge students receive during predoctoral dental education. Dentists considering the use of these advanced behavior guidance techniques should seek additional training through a residency program, a graduate program, and/or an extensive continuing education course that involves both didactic and experiential mentored training.

Hand Over Mouth (HOM)

Description: Hand over mouth is a technique for intercepting and managing demonstrably uncooperative behavior that cannot be modified by basic behavior guidance techniques. Its intent is to help the hysterical/obstreperous child regain self-control.

HOM is used to redirect inappropriate behavior, reframe a previous request, and reestablish effective communication. When indicated, the dentist's hand is placed gently over the child's mouth and behavioral expectations are explained calmly. Maintenance of a patent airway is mandatory. Upon the child's demonstration of self-control and more suitable behavior, the hand is removed and the child is given positive reinforcement. Communicative guidance techniques then should be used to alleviate the child's underlying fear and anxiety.

The need to diagnose and treat, as well as the safety of the patient, practitioner, and staff, should be considered for the use of HOM. The decision to use HOM must take into consideration:

1. Other alternate behavioral modalities
2. Patient's dental needs
3. The effect on the quality of dental care
4. Patient's emotional development
5. Patient's physical considerations
6. The potential for negative effect on the patient's attitude toward future appointments

Informed consent from a parent must be obtained and documented in the patient record prior to the use of HOM.

The patient's record must include:

1. Informed consent
2. Indication for use

Objectives:

1. Redirect the child's attention, enabling communication with the dentist so appropriate behavioral expectations can be explained
2. Extinguish excessive avoidance behavior and help the child regain self-control
3. Ensure the child's safety in the delivery of quality dental treatment
4. Reduce the need for sedation or general anesthesia

Indications: A healthy child who is able to understand and cooperate, but who exhibits obstreperous or hysterical avoidance behaviors

Contraindications:

1. Children who, due to age, disability, medication, or emotional immaturity, are unable to verbally communicate, understand, and cooperate
2. Any child with an airway obstruction

Protective Stabilization

Description: The use of any type of protective stabilization in the treatment of infants, children, adolescents, or persons with special health care needs is a topic that concerns healthcare providers, care givers, and the public. The broad definition of protective stabilization is the direct application of physical force to a

patient, with or without the patient's permission, to restrict his or her freedom of movement. The physical force may be human, mechanical devices, or a combination thereof. The use of protective stabilization has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of a patient's rights, and even death. Because of the associated risks and possible consequences of use, the dentist is encouraged to evaluate thoroughly its use on each patient and possible alternatives.

Partial or complete stabilization of the patient sometimes is necessary to protect the patient, practitioner, staff, or the parent from injury while providing dental care. Protective stabilization can be performed by the dentist, staff, or parent with or without the aid of a mechanical device. The dentist always should use the least restrictive but safe and effective restraint. The use of a mouth prop in a compliant child is not considered protective stabilization.

The need to diagnose, treat, and protect the safety of the patient, practitioner, staff, and parent should be considered for the use of protective stabilization.

The decision to use patient stabilization should take into consideration:

1. Other alternate behavior guidance modalities
2. Dental needs of the patient
3. The effect on the quality of dental care
4. Patient's emotional development
5. Patient's physical considerations

A dentist or dental staff performing protective stabilization with or without a stabilization device must obtain and document in the patient's record informed consent from a parent. Protective stabilization performed by a parent does not require informed consent. However, due to the possible aversive nature of the technique, informed consent should be obtained from the parent.

Informed consent from a parent must be obtained and documented in the patient record prior to protective stabilization. Also, an explanation to the patient regarding the need for restraint, with the opportunity for the patient to respond, must occur. In the event of an unanticipated reaction to dental treatment, it is incumbent upon the practitioner to protect the patient and staff from harm. Following immediate intervention to assure safety, if techniques must be altered to continue delivery of care, the dentist must have informed consent for the alternative methods.

The patient's record must include:

1. Informed consent
2. Indication for stabilization
3. Type of stabilization
4. The duration of application
5. Frequency of stabilization evaluation and safety adjustments
6. Behavior evaluation/rating during stabilization

Objectives:

1. Reduce or eliminate untoward movement
2. Protect patient, staff, dentist, or parent from injury
3. Facilitate delivery of quality dental treatment

Indications:

1. A patient who requires immediate diagnosis and/or limited treatment and cannot cooperate due to lack of maturity
2. A patient who requires immediate diagnosis and/or limited treatment and cannot cooperate due to mental or physical disability
3. When the safety of the patient, staff, dentist, or parent would be at risk without the protective use of stabilization
4. A sedated patient who requires limited stabilization to help reduce untoward movement

Contraindications:

1. A cooperative non-sedated patient
2. A patient who cannot be immobilized safely due to associated medical or physical conditions
3. A patient who has experienced previous physical or psychological trauma from protective stabilization (unless no other alternatives are available)
4. A non-sedated patient with non-emergent treatment requiring lengthy appointments

Precautions:

1. The tightness and duration of the stabilization must be monitored and reassessed at regular intervals
2. The stabilization around extremities or the chest must not actively restrict circulation or respiration
3. Stabilization should be terminated as soon as possible in a patient who is experiencing severe stress or hysterics to prevent possible physical or psychological trauma

Sedation

Description: Sedation can be used safely and effectively with patients unable to receive dental care for reasons of age or mental, physical, or medical condition. The need to diagnose and treat, as well as the safety of the patient, practitioner, and staff, should be considered for the use of sedation. Detailed information concerning the indications, contraindications, and additional clinical considerations may be found in the AAPD's Clinical Guideline on Elective Use of Minimal, Moderate, and Deep Sedation and General Anesthesia for Pediatric Dental Patients.

General Anesthesia

Description: General anesthesia is a controlled state of unconsciousness accompanied by a loss of protective reflexes, including the ability to maintain an airway independently and respond purposefully to physical stimulation or verbal

command. The use of general anesthesia sometimes is necessary to provide quality dental care for the child. Depending on the patient, this can be done in a hospital or an ambulatory setting, including the dental office. Detailed information concerning the indications, contraindications, and additional clinical considerations may be found in the AAPD's Clinical Guideline on the Elective Use of Minimal, Moderate, and Deep Sedation and General Anesthesia for Pediatric Dental Patients and Clinical Guideline on Use of Anesthesia Care Providers in the Administration of In-office Deep Sedation/General Anesthesia to the Pediatric Dental Patient.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

All oral health policies and clinical guidelines are based on 2 sources of evidence: (1) the scientific literature; and (2) experts in the field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

The goal of behavior guidance is to ease fear and anxiety while promoting an understanding of the need for good dental health and the process by which that is achieved. Communication between the dentist and child is built on a dynamic process of dialogue, facial expression, and voice tone. It is through this communication that the dentist can allay fear and anxiety, teach appropriate coping mechanisms, and guide the child to be cooperative, relaxed, and self-confident in the dental setting.

POTENTIAL HARMS

The use of protective stabilization has the potential to produce serious consequences, such as physical or psychological harm, loss of dignity, violation of a patient's rights, and even death.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Parental presence is contraindicated when parents are unwilling or unable to extend effective support (when asked).
- Voice control techniques are contraindicated in patients who are hearing impaired.
- Hand over mouth is contraindicated in children who, due to age, disability, medication, or emotional immaturity, are unable to verbally communicate, understand, and cooperate and in any child with an airway obstruction.
- Protective stabilization is contraindicated in

- A cooperative non-sedated patient
- A patient who cannot be immobilized safely due to associated medical or physical conditions
- A patient who has experienced previous physical or psychological trauma from protective stabilization (unless no other alternatives are available)
- A non-sedated patient with non-emergent treatment requiring lengthy appointments

QUALIFYING STATEMENTS

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The American Academy of Pediatric Dentistry (AAPD) recognizes that, in providing oral health care for infants, children, adolescents, and persons with special health care needs, a continuum of both nonpharmacological and pharmacological behavior guidance techniques may be used by dental health care providers. The various behavior guidance techniques used must be tailored to the individual patient and practitioner. Promoting a positive dental attitude, safety, and quality of care are of the utmost importance. This guideline is intended to educate health care providers, parents, and other interested parties about many behavior guidance techniques used in contemporary pediatric dentistry. It will not attempt to duplicate information found in greater detail in the AAPD Clinical Guideline on Appropriate Use of Nitrous Oxide for Pediatric Dental Patients and the Clinical Guideline on the Elective Use of Minimal, Moderate, and Deep Sedation and General Anesthesia for Pediatric Dental Patients.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatric Dentistry (AAPD). Clinical guideline on behavior guidance for the pediatric dental patient. Chicago (IL): American Academy of Pediatric Dentistry (AAPD); 2005. 12 p. [57 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 (revised 2005)

GUIDELINE DEVELOPER(S)

American Academy of Pediatric Dentistry - Professional Association

SOURCE(S) OF FUNDING

American Academy of Pediatric Dentistry

GUIDELINE COMMITTEE

Council on Clinical Affairs -- Committee on Behavior Guidance

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

None stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Academy of Pediatric Dentistry. Clinical guideline on behavior management. Chicago (IL): American Academy of Pediatric Dentistry; 2000. 6 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [American Academy of Pediatric Dentistry Web site](#).

Print copies: Available from the American Academy of Pediatric Dentistry, 211 East Chicago Avenue, Suite 700, Chicago, Illinois 60611

AVAILABILITY OF COMPANION DOCUMENTS

Information about the American Academy of Pediatric Dentistry (AAPD) mission and guideline development process is available on the [AAPD Web site](#).

The following implementation tools are available for download from the AAPD Web site:

- [Dental growth and development chart](#)
- [American Academy of Pediatric Dentistry Caries-Risk Assessment Tool \(CAT\)](#)

PATIENT RESOURCES

None available

NGC STATUS

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